Internal Audit Report

Maricopa Integrated Health System
Finance Office

July 2003

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July 31, 2003

Fulton Brock, Chairman, Board of Supervisors
Don Stapley, Supervisor, District II
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Mary Rose Wilcox, Supervisor, District V

We have completed our FY 2002-03 review of the Maricopa Integrated Health System (MIHS) Finance Department. The audit was performed in accordance with the annual audit plan approved by the Board of Supervisors.

The highlights of this report include the following:

- MIHS Ability to Pay Program (ATPP), established as a means to collect some payment for provision of medical services to the uninsured and to determine eligibility and enrollment of uninsured patients into an Arizona Health Care Cost Containment System (AHCCCS) health plan, does not appear to be fully recovering its service costs.
- Testing of manual advance claim payments showed that not all advances had been posted to provider accounts and that provider payments were still being processed instead of being applied against advance payment credit balances.
- Our review of 70 MIHS contracts found numerous exceptions to County policy requirements and contract terms, $220,000 of payments lacking appropriate Board of Supervisors' authorization, and control weaknesses that expose the County to legal and financial risk.
- The MIHS Finance Department does not take advantage of prompt payment discounts in order to maintain higher levels of cash on hand. Department financial reports show that discounts taken have declined from $74,900 in FY 2001 to $7,700 in FY 2003.
- IT controls need to be improved to ensure confidentiality, integrity, and availability of the finance system.

Attached are the report summary, detailed findings, recommendations, and MIHS' management response. We have reviewed this information with the Directors of the departments as well as the Medical Center Controller and Health Plans Controller. We appreciate the cooperation provided by management and staff. If you wish to discuss items presented in this report, please contact Eve Murillo at 506-7245.

Sincerely,

Ross L. Tate

Ross L. Tate
County Auditor

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Ability to Pay Program (Page 11)

MIHS' Ability to Pay Program, established as a means to collect some payment for provision of medical services to the uninsured and to determine eligibility and enrollment of uninsured patients into an Arizona Health Care Cost Containment System (AHCCCS) health plan, does not appear to be fully recovering its service costs. We also found significant control weaknesses and exceptions to the Board approved program requirements. MIHS should strengthen program controls and consider charging uninsured patients the full cost of providing non-emergency services until they are enrolled into an AHCCCS plan.

Advance Claim Payments (Page 13)

MIHS' implementation of its new claims payment system (OAO) initially delayed processing of providers' claim payments causing MIHS to manually advance $22 million to providers to reduce payment arrears. Our testing of a sample of manual check advances showed that as of May 2003, not all of the advance payments had been applied to the appropriate accounts. As a result, vendors were receiving additional payments for services when the payments should have been applied against credits in the accounts. Delays have made vendor account balances difficult to determine and hampered account reconciliation efforts. MIHS should improve claim payment processing activities and recover any overpayments, as expeditiously as possible.

Duplicate Claim Payments (Page 15)

We conducted a non-random test of medical claims processed through MIHS' two automated payment systems (OAO and INC) and found duplicate payments totaling $4,514 (1.2%) from OAO and $6,586 (3.6%) from INC. These percentages indicate that duplicate payments, during the test period, may total $272,480; the actual loss may be more or less than this amount. MIHS should strengthen controls over its claims payment procedures to minimize the risk of making duplicate payments.

Contract Administration (Page 17)

Our review of 70 MIHS contracts found numerous exceptions to County policy requirements and contract terms, $220,000 of payments lacking appropriate Board of Supervisors' authorization, and control weaknesses that expose the County to legal and financial risk. MIHS should strengthen its contract administration and monitoring controls, as well as, more closely adhere to Arizona Revised Statutes and County policy/procedural requirements.

Prompt Payment Discounts (Page 20)

The MIHS Finance Department does not take advantage of prompt payment discounts in order to maintain higher levels of cash on hand. The department's financial reports show that discounts

taken have declined from $74,900 in FY 2001 to $7,700 in FY 2003. On average, 31 percent of the invoices tested were 56 days old before being paid, which exceeds the department's goal of 45 days. MIHS should take advantage of cost savings offered through early payment discounts.

IT Best Practices (Page 22)

MIHS has adopted some best practice procedures related to local redundancy controls and computer operation practices. We would like to acknowledge these best practices, which show that management and staff are committed to an efficient and well-controlled data processing environment.

Change Management (Page 23)

MIHS business managers have been defined as responsible parties for approving program changes, however, the process for providing and tracking approval to move changes to production is informal. This practice increases the risk of system outages or performance issues, leading to increased expenses or lost data. MIHS should modify its policies and procedures to require formal approval of all program changes before they are moved from the test to production environments.

System Recovery (Page 24)

MIHS' finance system recovery management objectives, listed in the Disaster Recovery Plan (DRP), do not address all active modules. Also, application severity has been defined, however, recovery time objectives have not. These control weaknesses increase the risk that the system may not be recovered in a timeframe that meets business requirements. MIHS should include all modules of the finance system in the DRP as well as define the recovery times.

Data Integrity Testing (Page 26)

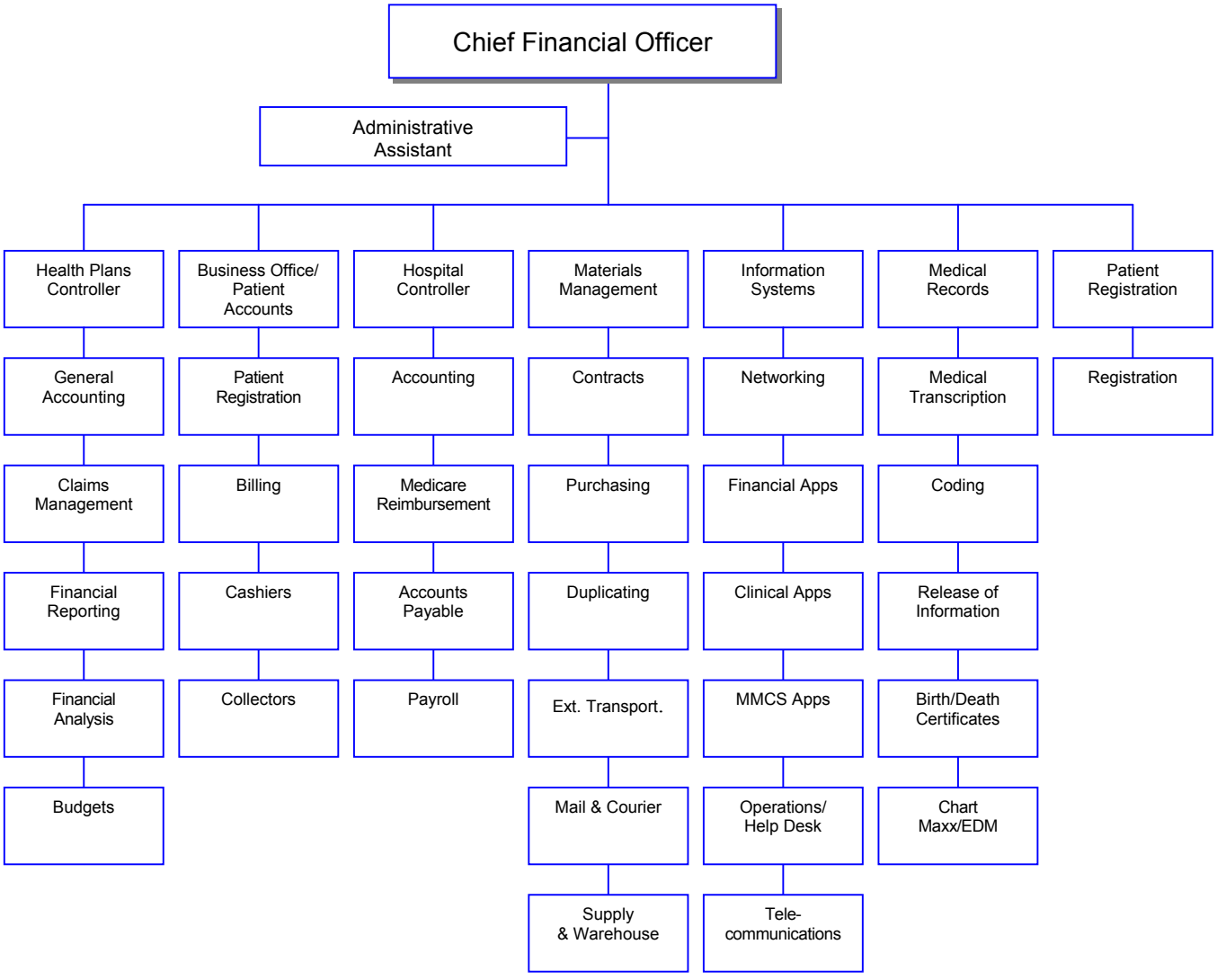
We identified discrepancies within the Patient Accounting Module's charge description master file, used to calculate a patient's bill. These control weaknesses increase the risk that patient billing may not be accurate. MIHS took action during the audit to correct the discrepancies. MIHS should now develop a process to validate data on an ongoing basis.

Introduction

Background

The Maricopa Integrated Health System (MIHS) Finance Department operates through the powers granted to the Board of Supervisors (Board) under Arizona Revised Statutes 11-251. The department provides reporting and analysis support for MIHS financial systems and processes account payments chargeable to MIHS. The department also prepares monthly and annual financial reports to assist the Board, the Hospital and Health System Board, and MIHS managers to make effective service delivery and fiscally sound operating decisions.

MIHS executive management team functions were outsourced to an external company until the management contract expired in June 2002. The County then hired the external management team as full-time County employees. The Chief Financial Officer (CFO) supervises the MIHS Finance Department. The following chart depicts the department's organizational structure:



Financial Results

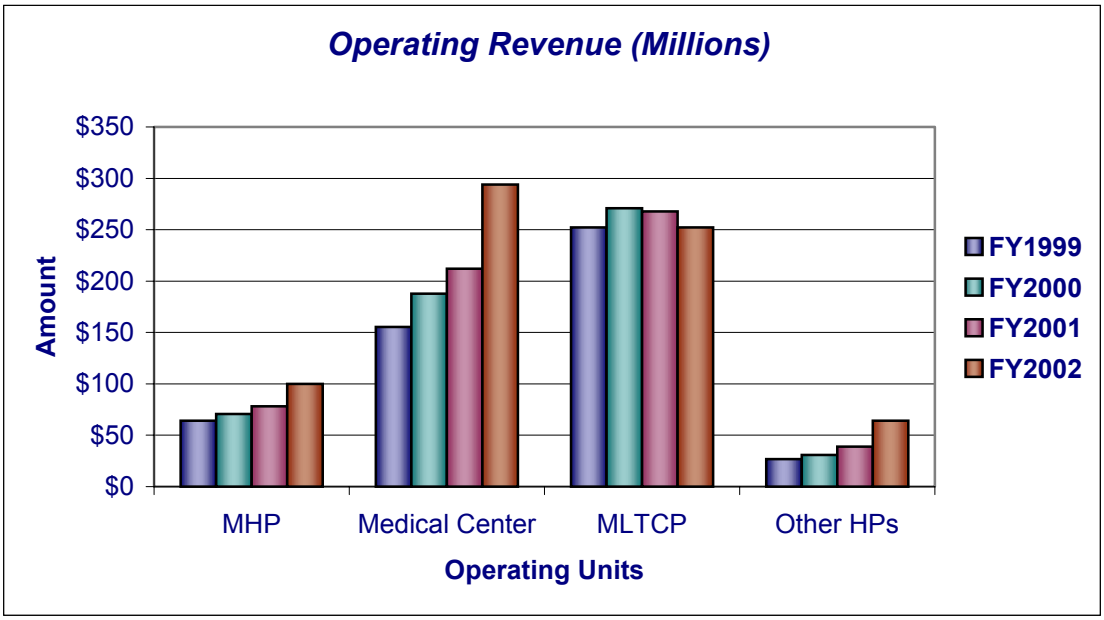
The following table displays FY02's year-end financial results as shown in the County's Comprehensive Annual Financial Report (CAFR):

FY02 COMPREHENSIVE ANNUAL FINANCIAL REPORT DATA					
	AHCCCS Health Plan	Medical Center	MLTCP ALTCS	Non-AHCCCS Health Plans	TOTAL
Operating Revenues	$100,104,747	$293,833,568	$252,343,614	$64,178,382	**$710,460,311**
Operating Expenses	$93,168,287	$335,428,872	$241,654,207	$66,767,140	**$737,018,506**
Unreserved Fund Equity	$0	($15,827,761)	$0	($182,869)	**($16,010,630)**
Operating Income before Transfers	$6,936,460	($41,595,304)	$10,689,407	($2,588,758)	**($26,558,195)**

The following table displays FY02's year-end financial results as shown in MIHS issued FY02 financial statements. The income shown in the table below includes other sources of income (such as grants and disproportionate share) not shown in the table above.

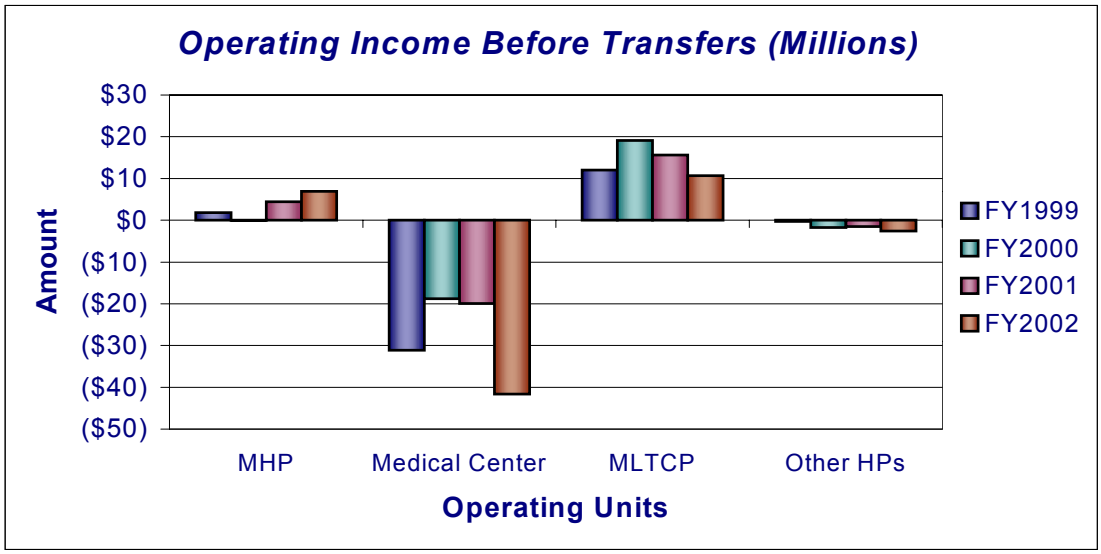
Income According to MIHS FY02 Financial Statement					
	AHCCCS Health Plan	Medical Center	MLTCP ALTCS	Non-AHCCCS Health Plans	TOTAL
Income	8,057,934	($24,835,784)	$14,647,012	($182,892)	**($2,317,612)**

The next graph shows operating revenue for the four MIHS operating units: Maricopa Health Plan (MHP), Maricopa Medical Center (MMC), Maricopa Long Term Care Plan (MLTCP), and other Health Plans (HP) - Senior Select and Health Select.



Source: Maricopa County CAFRs

The graph below shows operating income before any transfers for the four MIHS operating units. Negative numbers indicate that the operating unit had more operating expenses than operating revenue for the period. During FY 2002, the MLTCP Fund and MHP Fund (enterprise funds) transferred fund balances exceeding reserve requirements to the General Fund, totaling $40 million. The General Fund transferred the amount to the MMC enterprise fund. NOTE: We excluded transfers to provide a true picture of how each plan operates without subsidies from other sources.



Source: Maricopa County CAFRs

MIHS offers four health plans:

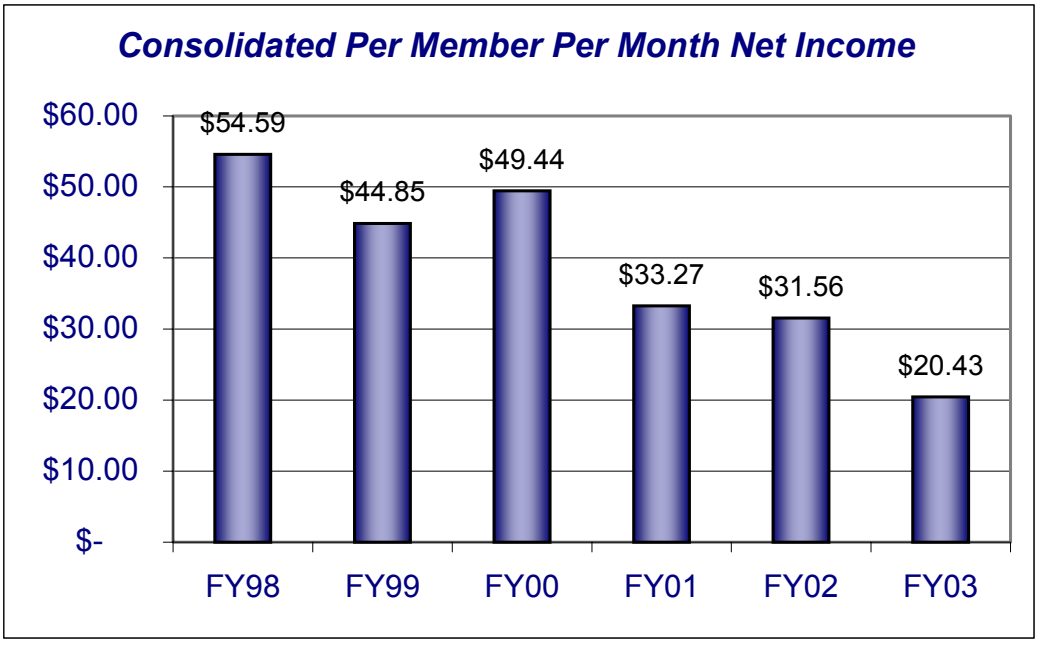
Health Select (HS): HS is an HMO medical plan for Maricopa County employees and their dependents. As of May 2003, HS served 6,225 members.

Maricopa Health Plan (MHP): MHP is an Arizona Health Care Cost Containment System (AHCCCS) plan funded through a State contract to serve all persons who meet AHCCCS eligibility income requirements. As of May 2003, MHP served 47,633 members.

Maricopa Long Term Care Plan (MLTCP): MLTCP provides services to those persons who meet AHCCCS eligibility income requirements and require specialized long-term care services in both home-based and nursing home settings. In October 2001, AHCCCS opened their Arizona Long Term Care System (ALTCS) program to competitive bids and MLTCP was no longer the sole contractor for the state ALTCS program in Maricopa County. As a result, membership and market share decline negatively impacted MLTCP net revenue. As of May 2003, MLTCP served 7,433 members.

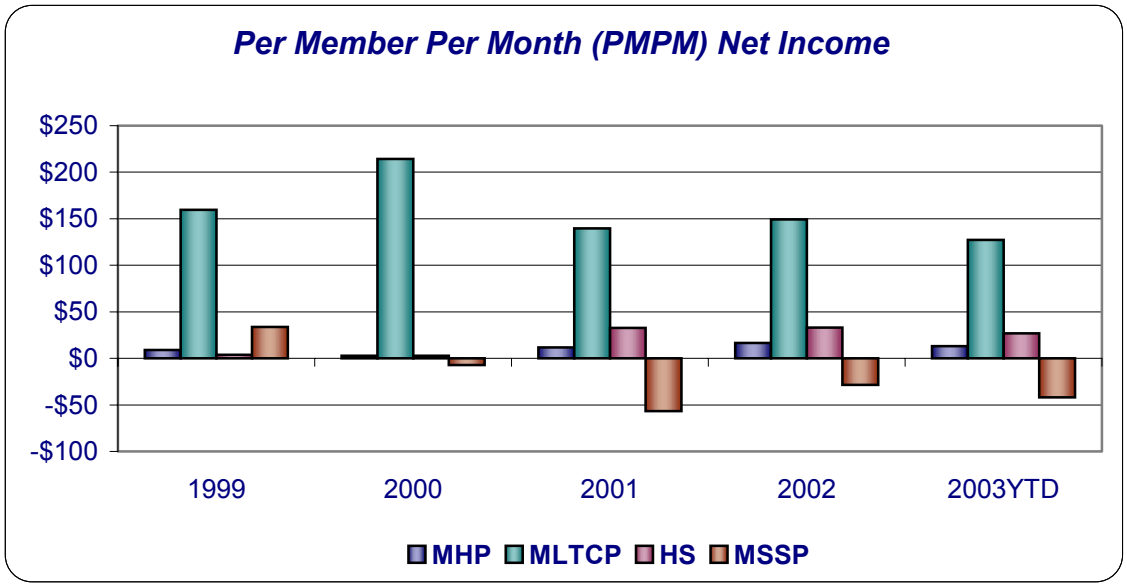
Maricopa Senior Select Plan (MSSP): MSSP is a Medicare+Choice HMO Plan offered to individuals eligible to receive Medicare benefits. (See the 2003 County MSSP audit for more plan information). As of May 2003, MSSP served 7,754 members.

Per Member Per Month (PMPM) net income is often used to assess the health plans' fiscal health. PMPM is calculated by dividing a plan's total net income by the total number of enrolled members. The following graph shows the declining rate of consolidated PMPM net income for MIHS' four health plans over the last five years, through fiscal year-to-date (May 2003).



Source: MIHS Monthly Financial Statements, CAFRs

The following graph shows individual health plan's PMPM net annual income/loss over the last five years through fiscal year-to-date (May 2003).



Source: MIHS Monthly Financial Statements, CAFRs

Financial Analysis

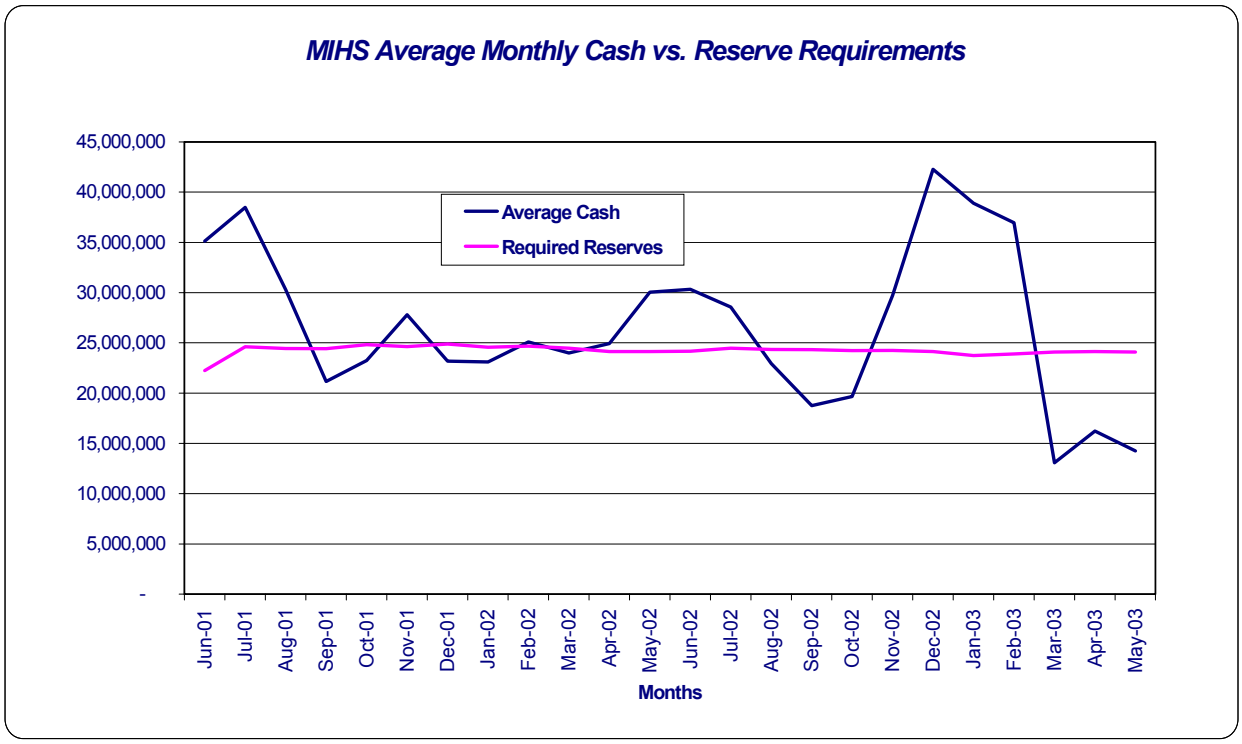
Equity per Member

AHCCCS requires that a minimum equity reserve be established for both MLTCP and MHP. The MLTCP contract, between the County and AHCCCS, set this amount at $2,000 equity reserves per member. The May 2003 MLTCP financials shows 7,433 MLTCP members; therefore, the required ALTCS equity is $14,866,000. The AHCCCS Health Plan requires $150 equity per member; and given 47,633 members reported by the May 2003 MHP financials, this program's required equity is $7,144,950. NOTE: These reserve amounts were considered when we analyzed MIHS' cash sufficiency (section below).

Month-End Cash Balances

The Treasurer's Fund Ledger MIHS daily cash balances for the last two years shows an overall decline. The MMC has consistently shown a negative cash balance, which has improved from negative $156 million (March 2002) to approximately negative $57 million (June 13, 2003). The AHCCCS plans (MLTCP and MHP) cash balance declined from $123 million (March 31, 2001) to $80.8 million (June 13, 2003). The non-AHCCCS plans (MSSP and HS) increased from $2.4 million (March 31, 2001) to $5.8 million (June 13, 2003).

During the last several quarters, MIHS combined cash balances have progressively declined. See the following graph, which is net of General Fund subsidies and disproportionate share.



Source: Maricopa County Department of Finance, Treasurer's General Ledger

MIHS replaced its INC claims processing system with OAO in November 2002. Due to problems with OAO implementation, claims received during November 2002 and beyond were not paid until March 2003 causing cash to increase. MIHS spending rose to $91 million in March 2003 (four month average prior to November 2002 was $59 million), showing that MIHS made efforts to catch up with the system-caused claims payment lag.

Accounts Payable

Accounts Payable is processed through the STAR financial system. As of February 2003, this amount was approximately $90 million for the health plans; half is Medical Claims Payable consisting of incurred but not reported (IBNR) and reported but unpaid (RBUC) claims. MMC had accounts payable of approximately $13 million.

Utilization

The MIHS delivery system customer base and financial health is strengthened when health plan members utilize its facilities. Utilization of MMC by MIHS health plan members continues to fall below budgeted figures because members go outside of the system for care. MIHS' May 2003 key indicators report shows utilization, by the different plans, as follows:

Plan	Utilization	Budgeted
Maricopa Health Plan	44%	55%
Maricopa Long Term Care Plan	28%	49%
Maricopa Senior Select Plan	28%	38%
Health Select	37%	34%

Program Operations

Claims Management

Due to OAO system implementation issues, claims payment processing was halted for several months and cash balances became artificially inflated. To ensure that smaller providers received adequate funding, MIHS began making pre-payments to nursing homes, dentists, adult foster care homes, and others. Per discussion with the MIHS Health Plan Controller, these pre-payments are reconciled to claim billings received from providers (see issue 2, page 13). To accrue for these claim payments, an 'Incurred But Not Reported' (IBNR) claims adjustment was made (included in Medical Claims Payable) for each of the four health plans. As a result of ceased claim payments, the estimate had to be inflated to ensure proper accrual for claims that were still being received.

Duplicate claim logic may not be properly setup in OAO to catch all duplicate claims submitted. MIHS has stated the logic has been corrected as of March 2003 and claims should be reversing duplicate payment amounts automatically (see issue 3, page 15).

AHCCCS conducted a review of MHP in August 2002 and noted that only 77.4 percent of clean claims were being paid within the 30-day contract requirement. AHCCCS also conducted a review of the MLTCP plan in December 2002 and found that claims processing could not be reviewed due to complications incurred with the November 2002 OAO system implementation.

STAR Financial Application

The STAR Financial application contains functionality to meet a wide range of clinical and financial needs for MIHS. The application contains several modules that include General and Patient Accounting. The General Accounting module consists of Accounts Payable, General Ledger, Payroll/Human Resources, and Materials Management. These four functional modules plus the Patient Accounting module make up the STAR Financial application used by MIHS.

Administration of the STAR Financial application has been outsourced to McKesson, a third party vendor, who is responsible for upgrades, fixes, backups, off-site file storage, account maintenance, user support, and system processing. Issues that pertain to system security will not be included in the report due to the confidential nature of the information and the risk to MIHS.

Scope and Methodology

Given the numerous functions performed by the MIHS Finance Department and to avoid duplicating work performed in other ongoing audits and reviews, the scope of this audit was limited to determining whether:

- Adequate procedures and controls have been established for advance claim payments made to providers, as a result of the OAO implementation
- The Ability to Pay Program is following the Board approved policy and, also, how well the program is working financially

- MIHS has effectively addressed the OAO system duplicate claims cleanup process and their level of compliance with established policies and procedures for processing medical claims within the OAO and INC systems
- Contracts are effectively administered and within Board approved not-to-exceed amounts
- Determine that access to the STAR finance system is properly restricted
- Determine that STAR program changes are properly authorized, tested, and approved

This audit was performed in accordance with generally accepted government auditing standards.

Issue 1 Ability to Pay Program (ATPP)

Summary

MIHS' Ability to Pay Program (ATPP), established as a means to collect some payment for provision of medical services to the uninsured and to determine eligibility and enrollment of uninsured patients into an Arizona Health Care Cost Containment System (AHCCCS) health plan, does not appear to be fully recovering its service costs. We also found significant control weaknesses and exceptions to the Board of Supervisors' approved program requirements. MIHS should strengthen program controls and consider charging uninsured patients the full cost of providing non-emergency services until they are enrolled into an AHCCCS plan.

Program Background

The County established ATPP in July 2002 to benefit patients who meet Federal poverty requirements but are still awaiting approval to be enrolled into AHCCCS plans. This process takes the State approximately six months to complete. The program was also developed as a means to generate revenue from uninsured patients who need non-emergency health care services. Current Federal laws does not require that the County provide patients with non-emergency health care regardless of their ability to pay for those services. A Board of Supervisors approved resolution dated June 27, 2002, states that the revised ATPP will allow MIHS to recoup, at a minimum, the costs of services provided.

One ATPP objective is to enroll uninsured patients into an AHCCCS health plan. Patients are initially allowed to stay in ATPP for 90 days. Each ATPP patient is placed into one of four levels designating payment amount in which the patient is required to make this minimum payment before services (excluding emergencies) are rendered. MIHS policy requires that payment be collected up front so that patient accounts receivable balances are not incurred. If denied AHCCCS enrollment, patients may remain in ATPP for up to one year. Any medical expenses incurred by the patient during this period can be used to reduce their annual income to help the patient re-qualify for AHCCCS; a practice referred to as "medical spend down."

Originally ATPP was only available for services rendered by MIHS staff. MedPro, a physician group contracted by MIHS to provide medical services, bills its patient services separately. Subsequent to ATPP's rollout, MedPro requested that MIHS bill patients for physician services before being admitted. MIHS agreed to remit any charges collected on behalf of MedPro, to the physician group, at the end of the month minus a four percent administration charge. The MIHS CFO reports that no financial analysis was performed to arrive at the four percent negotiated fee.

Review Results

The 2003 AHCCCS log maintained by MIHS shows 215 patients had been enrolled in ATTP, as of June 17, 2003. The log also shows that 61 (29%) of the patients had been confirmed enrolled into an AHCCCS plan and 23 (38%) selected MHP.

During our review and audit testing, we found the following control weaknesses and exceptions to the Board approved ATTP policy requirements:

- As of March 2003, MIHS showed an ATPP Accounts Receivable (A/R) balance of $269,000. Accounts greater than 90 days old showed a credit balance of $14,278. In theory there should be no A/R balance for ATPP as cash is to be collected before services are rendered. A credit balance (caused by charges not properly posting to the patient's account) represents money owed to the patient, which is incorrect. Subsequent to our audit work, the outpatient registration supervisor began auditing 100% of daily ATPP admits to ensure the proper amount is being collected.
- Patient account information shows that patients are allowed to stay in ATPP for longer than one year, causing the program to lose money. Account data is not consistently entered.
- MIHS is only collecting 10 percent of the gross charges incurred by ATPP patients. As a result, MIHS appears to lose money each time an ATPP patient is seen. At the time of our audit work, MIHS had not performed a financial analysis to determine if, at a minimum, costs are being covered by the program. Using MIHS Business Office reports, we calculate that 42,779 ATPP patient visits between August 2002 to April 2003 generated $11.6 million of gross charges. However, actual cash collected from these patients during this period was only $1.1 million (10% of gross charges incurred).

Recommendation

MIHS should:

A. Re-evaluate ATPP objectives and consider limiting non-emergency ATTP patient services below an acceptable cost recovery level.

B. Perform a break-even/financial analysis to determine if the four percent fee charged is adequate to recover its collection, reconciliation, and remittance costs.

Issue 2 Advance Claim Payments

Summary

MIHS' implementation of its new claims payment system (OAO) initially delayed processing of providers' claim payments causing MIHS to manually advance $22 million to providers to reduce payment arrears. Our testing of a sample of manual check advances showed that as of May 2003, not all of the advance payments had been applied to the appropriate accounts. As a result, vendors were receiving additional payments for services when the payments should have been applied against credits in the accounts. Delays have made vendor account balances difficult to determine and hampered account reconciliation efforts. MIHS should improve claim payment processing activities and recover any overpayments, as expeditiously as possible.

Background

As previously reported, MIHS switched its claims processing system from INC to OAO in November 2002. Claims received during November 2002 and beyond were not paid until March 2003. MIHS manually advanced providers approximately $22 million during this time to avoid late payments. Management made a decision to delay entry of advances into the OAO system until OAO check issuance problems could be researched and corrected.

Audit Test Results

Records show that MIHS management did not properly oversee or verify the entry of advance payments into OAO, which significantly delayed recognition of the payments. One advance payment was delivered to an adult foster care vendor in December 2002, however, the payment was not recognized in OAO, or applied to the vendor's account, until March 2003. Other advance payments made were found not to have been entered into OAO for up to two weeks after the payment was made, which appears excessive.

Confusion over vendors' account status exist because there are:

- Delays in the recognition of the advance payments made to the vendor by MIHS
- Delays between vendor-submitted claims' arrival at MIHS and the time the claims are received into the claims processing system (OAO). MIHS' stated claim turnaround time in their agreement with vendors does not start until the claim is received into OAO.

When advances are not entered into OAO in a timely fashion, further delays in the recovery and application of current charges against account credit balances occur.

Our testing of twelve advances, made via manual checks, showed a significant delay between check issuance and OAO data entry. The average number of days from check date to entry into OAO was 55 days. Six advances tested (50%) had yet to be recovered from provider accounts at the time of testing. One $150,000 advance (February 12, 2003) made to a care center had not yet been entered into OAO as of June 9, 2003. Subsequent to the February 12, 2003, manual

check advance, additional monies were paid to the same care center for claims submitted; monies that should have been applied against the $150,000 credit in the care center's account.

Recommendation

MIHS should:

A. Date stamp each claim or batch of claims when they arrive in the mailroom.

B. Segregate claim batches and set a priority over other claim submissions, since turnaround time is less for the adult foster care claims.

C. Record manual checks issued to providers in OAO, as soon as possible.

D. Perform a full audit of manual check advances issued to providers to ensure they are entered into OAO and are properly being recouped.

Issue 3 Duplicate Claim Payments

Summary

We conducted a non-random test of medical claims processed through MIHS' two automated payment systems (OAO and INC) and found duplicate payments totaling $4,514 (1.2%) from OAO and $6,586 (3.6%) from INC. These percentages indicate that duplicate payments, during the test period, may total $272,480; the actual loss may be more or less than this amount. MIHS should strengthen controls over its claims payment procedures to minimize the risk of making duplicate payments.

Claims Payment Analysis

Various contractual provisions require MIHS to process service provider billings promptly. This practice is also necessary in order to:

- Conduct business in an effective and efficient manner
- Ensure that providers do not submit more than one claim for the same service
- Help MIHS avoid making duplicate payments. NOTE: Many companies also conduct tests to identify any duplicate payments and potential fraudulent activity.

We reviewed OAO claim payment downloads for the period November 1, 2002 through March 31, 2003 and INC claims from July 1, 2001 through October 1, 2002. During testing we summarized claim files where member number, amount paid, beginning date of service, procedure code, and provider are equal. We then judgmentally selected 47 potential duplicates from the OAO system and 38 from the INC system. We conducted further investigation to determine if the claims were duplicates. We noted:

- Test sample payments taken from the OAO population contained duplicate payments totaling $4,514 (1.2 %) of the payments made.
- Duplicate payments from the INC test sample contained duplicate payments totaling $6,586 (3.6 %) of the payments made.
- Applying these percentages to the total potential duplicate population of $4.3 million INC and $9.4 million OAO, potential losses for the period may total approximately $272,480.

We also performed a Benford's Law test on the payment download. This analysis is a mathematical test that predicts the normal pattern of payments. Displays of payments that do not conform to the norm indicate potential error or fraud. We found spikes showing an unusually high number of similar payment amounts. Due to limited audit resources we were not able to test a larger population and, therefore, limited our testing to the above sample. Not surprising, each duplicate payment noted in our testing fell exactly within one of the anomalous spikes from the Benford's Law analysis. Further investigation is warranted to determine if possible errors or inefficiencies exist beyond what the duplicates testing showed.

Possible Causes

Based on our discussions with MIHS staff, all sample duplicate claims were verified and found to be the result of human errors made during payment processing. None of the duplicate claims had been reversed and the monies had not been recovered at the time of testing. Management explained that the INC system was outdated and could not automatically detect duplicate payments. The INC manufacturer was not responsive to provide MIHS with a duplicate report because the system was being converted to OAO. We also found an OAO system error that occurred in March 2003. Multiple claims were automatically paid, however, and the system did not check for duplicate payments.

Recommendation

MIHS should:

A. Monitor duplicate claims more proactively and train processors to look for common errors. When patient ID, dates of service, provider, and amounts are identical the risk of duplicate payments is very high.

B. Research and adjust, if applicable, identified potential duplicate claims.

C. Recover any duplicate payments made.

Issue 4 Contract Administration

Summary

Our review of 70 MIHS contracts found numerous exceptions to County policy requirements and contract terms, $220,000 of payments lacking appropriate Board of Supervisors' authorization, and control weaknesses that expose the County to legal and financial risk. MIHS should strengthen its contract administration and monitoring controls, as well as, more closely adhere to Arizona Revised Statutes (ARS) and County policy/procedural requirements.

Contract Regulations

Maricopa County Procurement Code requires that:

- The Board of Supervisors must approve all Contracts unless specifically delegated by the Board or authorized by the Procurement Code
- Payment for any materials or services shall not be made unless pursuant to a written contract procured under the Procurement Code
- A Procurement Officer shall not incur an obligation on behalf of Maricopa County if sufficient funds are not available

Article 13 of the Procurement Code grants the MIHS Chief Procurement Officer authority to exercise all contractual rights and provisions of Board approved MIHS contracts that do not have an estimated value in excess of $100,000 per year or a term greater than five years. MIHS is also required to supply copies of all Article 13 contract amendments to the Clerk of the Board. Additionally, MIHS Policy & Procedure 6020 requires the Contracts Department to identify essential services contracts up for renewal within 60-120 days.

Contract Testing Results

We reviewed a sample of MIHS contracts and supporting documentation for compliance with applicable County regulations and important contract provisions. We found the following exceptions.

Contract Amendments: We reviewed 70 contracts and found that 31 were done pursuant to Article 13 provisions. Records show that 27 amendments were made retroactively to these 31 contracts, which violates County policy. Eleven of the amendments were extensions of expired MIHS contracts.

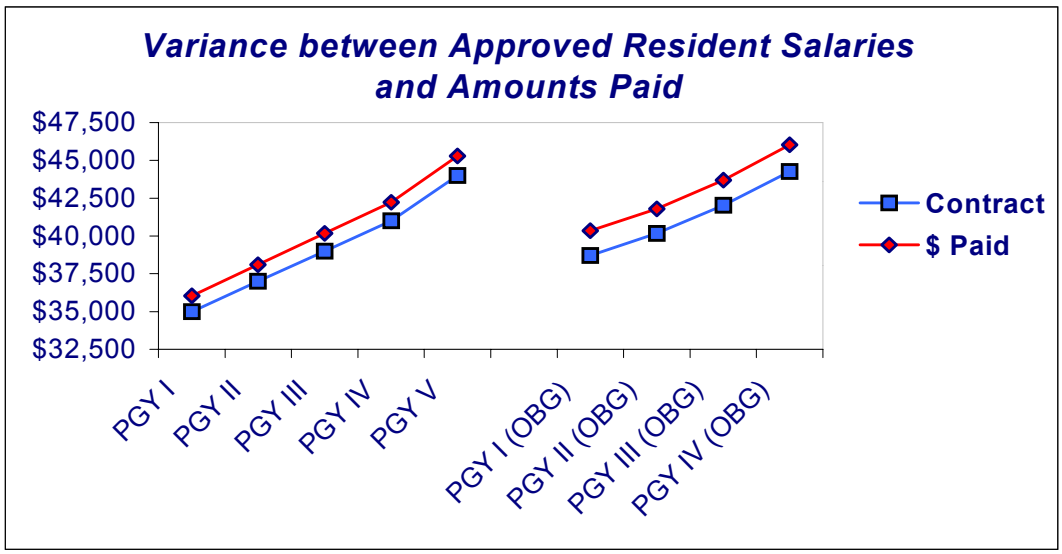
NOTE: This exception has been noted by Internal Audit in several prior year audits. MIHS often overlooked the County policy requirement in the past but has improved compliance, over the past year, upon Clerk of the Board insistence.

We also found 14 instances within current FY 2003 contracts where MIHS requested retroactive actions. The results are summarized as follows:

- Seven were extensions of contracts that had previously expired; one extension included County Counsel opinion stating that retroactive contracts and/or amendments are legal and justified due to "contract renegotiations, administrative errors or funding delays."
- Ten were retroactive increases to Board approved Not to Exceed (NTE) amounts; three times the established NTEs were previously surpassed and cost over-runs were cited as justification. NOTE: Paying contractors in excess of contract amounts violates ARS 11-251 and the County Procurement Code.
- MIHS requested on June 4, 2003 an amendment to increase MMC leased space retroactive to July 1, 2002. During the intermediary period, MIHS did not collect the additional lease revenue ($3,257 per month). MIHS' failure to execute contract changes without first obtaining Board approval exposed the County to the risk of losing $35,948, not including interest. NOTE: MIHS billed the lessee retroactively for the adjustments on May 29, 2003.
- MIHS requested the Board to retroactively increase a contract's NTE amount, as the initial agenda item understated the total NTE amount (two combined contracts) by $7 million. After Internal Audit's notification, the Clerk of the Board will obtain a correction.

Contract History Gap: We found an MIHS contract having undocumented changes made to contract terms. The contract, on file with the Clerk of the Board, does not have a Board amendment approving a $560,000 increase to the NTE amount.

Contract Approval: We found that in FY 2003, MIHS paid a pool of contracted medical resident physicians $220,000 without appropriate Board of Supervisors' authorization. These payments exceeded the total contract amount by three percent. Residents are contract employees therefore contract amendments are needed to change their pay rate. MIHS improperly used a personnel agenda instead of contract amendments to enact these pay rate changes. The variance between payments and approved contract terms are illustrated below. The designations PGY1, etc., indicate "Program Graduate Year 1", etc.



Recommendation

MIHS should:

A. Review and comply with ARS, County financial policies, and Procurement Code requirements.

B. Strengthen controls over contract renewals and NTE monitoring activities.

C. Review contracted employees' files, identify all inaccuracies, and prepare/submit retroactive amendments to reflect necessary changes.

D. Strengthen controls for preparing/submitting agenda items for Board approval.

Issue 5 Prompt Payment Discounts

Summary

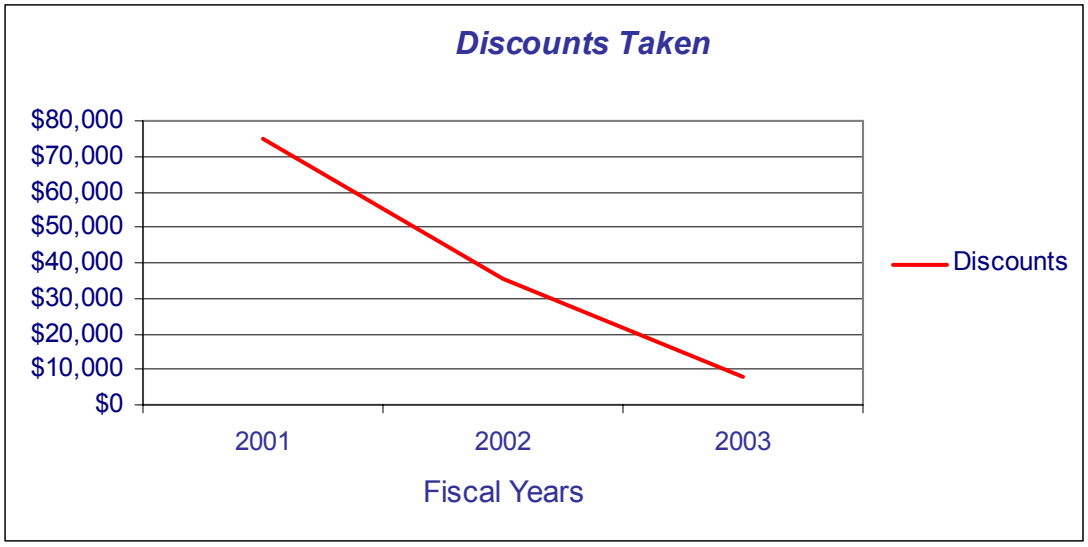
The MIHS Finance Department does not take advantage of prompt payment discounts in order to maintain higher levels of cash on hand. The department's financial reports show that discounts taken have declined from $74,900 in FY 2001 to $7,700 in FY 2003. On average, 31 percent of the invoices tested were 56 days old before being paid, which exceeds the department's goal of 45 days. MIHS should take advantage of cost savings offered through early payment discounts.

Requirements

The American Institute of Certified Public Accountants (AICPA) Government Accounting and Financial Reporting Manual states that responsibility for claiming cash discounts should be clearly identified. MIHS has set an accounts payables' goal to pay invoices accurately and timely within contract terms or 45 days. County management has stressed that departments take advantage of all available prompt payment discounts, identifying discount utilization as an important component to efficient budgetary administration.

Review Results

The MIHS Finance Department reports that vendor offered early payment discounts are not being taken in order to maintain higher levels of cash on hand. The chart below reflects a sharp decline in prompt payment discounts taken.



We reviewed MIHS Finance Department's paid invoices and found the following:

- Average payment turnaround was 56 days for 31 percent of the invoices reviewed.

- Payment terms and information on discounts and/or penalties are not accurately inputted to the STAR payment system. Of 18 vendors reviewed, 9 had payment terms defined in their contracts, which was either absent or incorrect in the STAR system. The system also does not differentiate between available prompt payment discounts and late payment penalties.
- 664 of 2,146 (31%) of vendor invoices tested were paid in excess of 45 days post invoice receipt. The average payment period was 56 days.

Recommendation

MIHS should:

A. Take advantage of all cost savings offered through early payment discounts.

B. Ensure that STAR System contract payment terms are accurate.

Issue 6 IT Best Practices

Summary

MIHS has adopted some best practice procedures related to local redundancy controls and computer operation practices. We would like to acknowledge these best practices, which show that management and staff are committed to an efficient and well-controlled data processing environment.

Redundancy Controls

The MIHS finance system server has a RAID 5 hard disk array, full replication, and automatic fail over in place between the finance and clinical system servers. Idle hardware is available in the computer room that has the capability of running the finance system in the event of system failure. The server room is on an uninterruptible power supply (UPS) expected to provide approximately 30 minutes of backup power under current load conditions. Additionally, a generator designed to provide emergency power to the hospital, including the computer room, is in place.

This backup plan covers the finance system only if a hardware or software failure occurs locally. The backup plan does not cover a disaster situation where there is no access to the computer center. Some improvements are needed in the disaster recovery procedures and are outlined in issue 8 – System Recovery.

Computer Operations

During our review, we also noted that a daily checklist is consistently used to track the numerous tasks performed each day. The checklist gives detailed instructions as to what jobs are run and when. Staff is required to initial each task once it is completed. Problems are also noted on the checklist so that when there is a shift change, staff is aware of these situations. This procedure provides good control and helps to ensure that each task is completed and that all errors are resolved timely.

Another item worth noting is that the System Access Request forms are consistently being used to request and approve set-up for new accounts as stated in the policies and procedures. Although deviations were noted for older accounts, additional testing revealed that the process appears to be consistently followed for accounts created since the process was implemented in 1998.

Recommendation

None, for information only.

Issue 7 Change Management

Summary

MIHS business managers have been defined as responsible parties for approving program changes, however, the process for providing and tracking approval to move changes to production is informal. This practice increases the risk of system outages or performance issues, leading to increased expenses or lost data. MIHS should modify its policies and procedures to require formal approval of all program changes before they are moved from the test to production environments.

Industry Best Practice

Industry best practice requires that thorough testing of application program changes be performed before changes are applied to the production environment. Thorough testing decreases the risk of unexpected negative impacts on the environment.

Risk

During our testing, we observed that the process for obtaining approval from business managers to move changes from test to production is informal. We also noted that if approval is not obtained, changes may still be moved into production. System outages or performance issues may result in unforeseen negative impacts on the production environment ultimately resulting in increased expenses or lost data. Current policies do not require formal approval of all program changes before they are moved from the test to production environments.

Recommendation

MIHS should:

A. Modify policies and procedures to require formal approval of all program changes before they are moved from the test to production environments.

B. Modify procedures to include criteria for determining when a change is considered an emergency change and the approval requirements including the timeframe.

C. Retain approvals to provide an audit trail in the event of unforeseen negative impacts on the production environment.

Issue 8 System Recovery

Summary

MIHS' finance system recovery management objectives, listed in the Disaster Recovery Plan (DRP), do not address all active modules. Also, application severity has been defined, however, recovery time objectives have not. These control weaknesses increase the risk that the system may not be recovered in a timeframe that meets business requirements. MIHS should include all modules of the finance system in the DRP as well as define the recovery times.

Disaster Recovery Plan

Best practices require that a comprehensive DRP include all critical business systems, as well as, system recovery objectives. We observed that the MIHS finance system's payroll and materials management modules are not included in the DRP plan. Recovery objectives also have not been established, based on the ability to rely on manual MIHS processes before critical systems are restored.

If a hard disk failure or other catastrophic event were to happen, the finance system may not be recovered in a timeframe that meets business requirements. The current DRP does not establish recovery requirements, as a function of time, and has not been updated to include all system modules.

Recovery Procedures

IT best practices require that critical systems be recovered from backup tapes periodically. The number of tapes, and number of uses, must also be tracked to ensure that the tapes are not used beyond manufacturer specifications. MIHS may not be able to restore the finance system, or other systems, from backup tapes in the event of a hard disk failure or other catastrophic event. Also, data may be inaccessible for tapes that have been used more than manufacture specifications. Processes have not been established to alleviate these risks.

Off-Site Tape Storage

MIHS systems and data backups should be securely stored off-site and should only be made available to approved personnel. Our testing showed that the list of approved personnel to recover tapes from the off-site vendor included two individuals no longer employed by MIHS. Also, information cards had not been distributed to persons responsible for restoring systems in the event of a disaster.

These control weaknesses increases the risk that terminated individuals may obtain and destroy backup tapes stored off-site. MIHS has not developed processes to ensure that terminated individuals, with access to off-site tapes, are removed from the access list or to distribute information cards to individuals responsible for recovering tapes from the off-site vendor.

Recommendation

MIHS should:

A. Update the DRP to include the payroll and materials management modules of the finance system.

B. Establish recovery objectives considering the amount of time that the business can function using manual processes before critical systems are restored.

C. Formalize processes to periodically test the ability to recover systems from backup tapes, track the number of uses and age of backup tapes, and replace tapes when necessary.

D. Retain formal documentation supporting periodic tests to recover systems.

E. Remove the terminated employees from the approved list to obtain tapes from the backup site and establish a process to ensure that individuals are removed promptly upon termination.

F. Distribute information cards to individuals responsible for obtaining tapes from the off-site vendor and instruct these individuals to carry the cards with them at all times, i.e., in their wallet or purse.

Issue 9 Data Integrity Testing

Summary

We identified discrepancies within the Patient Accounting Module's charge description master file, used to calculate a patient's bill. These control weaknesses increase the risk that patient billing may not be accurate. MIHS took action during the audit to correct the discrepancies. MIHS should now develop a process to validate data on an ongoing basis.

Billing

The STAR system should accurately and completely code all patient medical services and billed charges to the appropriate payer in accordance with applicable regulations, laws, and contracts. The system should also bill patients consistently and uniformly for services. Inaccurate data in the system could result in incorrect patient billing.

We found 211 duplicate numbers in the charge description master file. These numbers are used, among other things, to calculate a patient's bill. Inaccurate information in the charge master file may result in inaccurate patient billing.

Revenue

In addition, eleven charge numbers were not associated with a revenue department in the charge description master file. As a result, the revenue was not directed to the proper department. It appears the revenue was not reflected anywhere. These errors resulted from the manual process used to add or update the charge description master file. MIHS took action during the audit to correct the discrepancies.

Recommendation

MIHS should develop a process to check for data input errors after entry into the system on an on-going basis.

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Department Response

MARICOPA
HEALTH SYSTEM
Count on us to care.

Maricopa Integrated Health System

2601 E. Roosevelt
Phoenix, AZ 85008
Phone: (602) 344-8444 Fax: (602) 344-5190

DATE: Tuesday, July 15, 2003

TO: Ross Tate, Internal Audit

FROM: Pat Walz

SUBJECT: **Internal Audit Report of MIHS Finance Office – July 2003**

Thank you for the opportunity to respond to the various recommendations noted in this audit document. This is a rather extensive audit and obviously covered many areas including the Hospital Finance Department, Health Plan Finance Department and Information Technology.

I appreciate the speed with which the audit was completed and the professionalism displayed by your staff.

AUDIT RESPONSE
MARICOPA INTEGRATED HEALTH SYSTEM
FINANCE OFFICE JULY 2003

ISSUE 1 – ABILITY TO PAY PROGRAM (ATPP)

Issue #1:

MIHS' Ability to Pay Program (ATPP), established as a means to collect some payment for provision of medical services to the uninsured and to determine eligibility and enrollment of uninsured patients into an Arizona Health Care Cost Containment System (AHCCCS) health plan, does not appear to be fully recovering its service costs. We also found significant control weaknesses and exceptions to the Board approved program requirements. MIHS should strengthen program controls and consider charging uninsured patients the full cost of providing non-emergency services until they are enrolled into an AHCCCS plan.

Response: Concur with reservations. We agree that one of the objectives of the Ability to Pay Program, as approved June 27, 2002 was to recoup the cost of services provided. No analysis was done on what the full cost or variable cost of providing these non-emergency services are, so that to say we are not recovering the full cost is premature. Additionally, another objective of the Ability to Pay Program was to provide guidance for the financial counselors in the clinics. A year-to-year comparison of cash payments by patients into the delivery system shows an increase of approximately $300,000. Further it allows us an opportunity to help the patients enroll in AHCCCS and choose an AHCCCS plan. Prior to Prop 204 this was not done for outpatients. Under the new regulations, treat and release patients are allowed to fill out AHCCCS applications. This has been a very successful part of the Ability to Pay Program. As noted in the internal audit, 29% of the patient enrolled in Ability to Pay were confirmed as being enrolled into an AHCCCS plan.

Recommendation A: Re-evaluate ATPP objectives and consider limiting non-emergency ATPP patient services below an acceptable cost recovery level.

Response: Do not concur. We currently have one year experience with asking patients to pay at the clinic locations. It would be premature to force the payment higher that is currently requested. We are proposing some minor changes in the Ability to Pay Program to take affect August 1, 2003. Changing a culture of payment for services is a long process. Any additional changes should be deferred until the end of FY04.

Target Completion Date: Not applicable

Benefits/Costs: None

Recommendation B: Perform a break-even/financial analysis to determine if the four percent fee charged is adequate to recover its collection, reconciliation, and remittance costs.

Response: Concur with reservations. The four percent was negotiated with Medpro. The theory behind the four percent was that the third party market runs between eight and twelve percent for billing and collection services that are outsourced. Since we will not be producing any bills nor will we be following any accounts receivable, it was felt that four percent was a fair price for collecting the money and issuing a check to Medpro. We have not begun this process and since we have no history, any breakeven analysis would be total conjecture. We would prefer to wait and develop a history with this rule in place to see how material the collections actually are and what amount of time is invested in rebating this money to Medpro.

Target Completion Date: June 30, 2004

Benefits/Costs: None

ISSUE 2 – ADVANCE CLAIM PAYMENTS

Issue # 2:

MIHS' implementation of its new claims payment system (OAO) initially delayed processing of providers' claim payments causing MIHS to manually advance $22 million to providers to reduce payment arrears. Our testing of a sample of manual check advances showed that as of May 2003, not all of the advance payments had been applied to the appropriate accounts. As a result, vendors were receiving additional payments for services when the payments should have been applied against credits in the accounts. Delays have made vendor account balances difficult to determine and hampered account reconciliation efforts. MIHS should improve claim payment processing activities and recover any overpayments, as expeditiously as possible.

Response: Do not concur. All advance payments have been applied to provider's accounts. The $6.5 million referenced is the net credit balances shown in the provider's account resulting from the application of the advances. Vendors who owe advances are not receiving additional payments.

Recommendation A: Date stamp each claim or batch of claims when they arrive in the mailroom.

Response: Concur – completed. No action is necessary, as this has been done since the conversion to OAO occurred on October 27, 2002.

Target Completion Date: October 27, 2002.

Benefits/Costs: Compliance with regulatory requirements.

Recommendation B: Segregate claims batches and set a priority over other claims submission, since turnaround time is less for the adult foster care claims.

Response: Concur – completed. No action is necessary, as this has been done since the priority process of adult foster care claims has been in place since December 31, 2002.

Target Completion Date: December 31, 2002.

Benefits/Costs: Expedited recovery of adult foster care advances and improved provider satisfaction.

Recommendation C: Record manual checks issued to providers in OAO, as soon as possible.

Response: Concur – completed. No action is necessary, as this has been done since the recovery process began on March 17, 2003. In regards to the delay between check date and entry into OAO, senior management made a decision to delay the recovery of advance payments until the paid claims level in OAO was such that the providers would have began to receive routine payments. Since March 17, 2003, advances are entered into OAO approximately one and one-half weeks after disbursement. The delay is necessitated by timing of check runs.

Target Completion Date: March 17, 2003.

Benefits/Costs: Expedited recovery of advances and improved provider satisfaction.

Recommendation D: Perform a full audit of manual checks advances issued to providers to ensure that they are entered into OAO and are properly being recouped.

Response: Concur – in process. Advance audit began on July 3, 2003

Target Completion Date: August 31, 2003.

Benefits/Costs: Recovery of advances and improved MIHS cash levels.

ISSUE 3 – DUPLICATE CLAIM PAYMENTS

Issue #3:

We conducted a non-random test of medical claims processed through MIHS' two automated payment systems (OAO and INC) and found duplicate payments totaling $4,514 (1.2%) from OAO and $6,586 (3.6%) from INC. These percentages indicate that total duplicate payments, during the test period, may be $242,480; actual loss may be more or less than this amount. MIHS should strengthen controls over its claims processing procedures to minimize the risk of making duplicate payments.

Response: Concur.

Recommendation A: Monitor duplicate claims more proactively and train processors to look for common errors. When patient ID, dates of service, provider, and amounts are identical the risk of duplicate payments is very high.

Response: Concur – completed. This has consistently been done as a normal course of business and will continue into the future. MIHS periodically runs a process that scans all claims, both pended and paid, for duplication that recovers paid claims or denies pended claims when duplicates are found to exist. We anticipate converting this from a periodic process to weekly by August 31, 2003.

Target Completion Date: August 31, 2003.

Benefits/Costs: Compliance with regulatory requirements.

Recommendation B: Research and adjust, if applicable, identified potential duplicate claims.

Response: Concur – completed. No action necessary as this has consistently been done as a normal course of business.

Target Completion Date: Not applicable.

Benefits/Costs: Compliance with regulatory requirements.

Recommendation C: Recover any duplicate payments made.

Response: Concur – completed. No action necessary as this has consistently been done as a normal course of business.

Target Completion Date: Not applicable.

Benefits/Costs: Compliance with regulatory requirements.

ISSUE 4 – CONTRACT ADMINISTRATION

Issue #4:

Our review of 70 MIHS contracts found numerous exceptions to County policy requirements and contract terms, $220,000 of payments lacking appropriate Board of Supervisors' authorization, and control weaknesses that expose the County to legal and financial risk. MIHS should strengthen its contract administration and monitoring controls, as well as, more closely adhere to ARS and County policy/procedural requirements.

Recommendation A: Review and comply with ARS, County Financial Policies, and Procurement Code requirements.

Response: Concur—In process. Efforts are under way to minimize retroactive contract approvals/changes and improve NTE monitoring activities. MIHS Contracts Department staff and management are working closely with contractors and key MIHS/County departments to reduce retroactive approvals/NTE discrepancies.

Target Completion Date: 9/1/03

Benefit: Compliance with state law.

Recommendation B: Strengthen controls over contract renewals and NTE monitoring activities.

Response: Concur—In Process. Efforts are under way to minimize retroactive contract approvals/changes and improve NTE monitoring activities. MIHS Contracts Department staff and management are working closely with contractors and key MIHS/County departments to reduce retroactive approvals/NTE discrepancies.

Target Completion Date: 12/1/03

Benefit: Compliance with state law.

Recommendation C: Review contracted employees' files, identify all inaccuracies, and prepare/submit retroactive amendments to reflect necessary changes.

Response: Concur. Retroactive contract approval currently on Agency Central.

Target Completion: July 30, 2003

Benefit: none

We found some MIHS contracts having undocumented changes made to contract terms. One contract, on file with the Clerk of the Board, does not have a Board amendment

approving a $560,000 increase to the NTE amount. In a separate contract, we could not find support to increase leased space by 1,075 square feet.

Recommendation D: Strengthen controls for preparing/submitting agenda items for Board approval.

Response: Concur. MIHS Contract Administration will investigate the $560,000 NTE discrepancy identified and update the contract file and/or obtain Board approval if necessary. The increase to the leased space was approved on 10/17/01 via agenda # c-90-02-040.

Target Completion Date: 9/1/03

Benefit: Compliance with state law.

Results:
MIHS requested the Board to retroactively increase a contract NTE amount, as the initial agenda item understated the total NTE amount (two combined contracts) by $7 million.

Response: Concur--completed. For clarification, there was a discrepancy within the two contract NTE amounts but the total NTE amount was unchanged.

ISSUE 5 – PROMPT PAYMENT DISCOUNTS

Issue #5:

The MIHS Finance Department does not take advantage of prompt-pay discounts in order to maintain higher levels of cash on hand. The department's financial reports show that discounts taken have declines from $74,900 in FY 2001 to $7,700 in FY 2003. On average, 31 percent of the invoices tested were 56 days old before being paid, which exceeds the department's goal of 45 days. MIHS should take advantage of cost savings offered through early payment discounts.

Recommendation A: Take advantage of all cost savings offered through early payment discounts.

Response: We do not concur with this recommendation.
Senior Management made a conscious decision not to take advantage of prompt pay discounts as the cash balances combined had decreased significantly (see page 8). It would be inappropriate to process payments more quickly when cash balances are below cash reserves.

Target Completion Date: Not applicable

Benefit: none

Recommendation B: Ensure that STAR System contract payment terms are accurate.

Response: Concur – this is a normal part of doing business when the contracts are loaded.

Target Completion Date: Complete

Benefit: none

ISSUE 6 – IT BEST PRACTICES

Issue #6:

MIHS has adopted some best practice procedures related to local redundancy controls and computer operations. We would like to acknowledge these best practices, which show that management and staff are committed to an efficient and well-controlled data processing environment.

Response: Concur

Recommendation: None, for information only.

ISSUE 7 – CHANGE MANAGEMENT

Issue #7:

MIHS business managers have been defined as responsible parties for approving program changes, however, the process for providing and tracking approval to move changes to production is informal. This practice increases the risk of system outages or performance issues, leading to increased expenses or lost data. MIHS should modify its policies and procedures to require formal approval of all program changes before they are moved from the test to production environments.

Response: Concur

Recommendation A: Modify policies and procedures to require formal approval of all program changes before they are moved from the test to production environments.

Response: Concur—In process. MIHS HIT will leverage the Information Technology Infrastructure Library (the Information Technology Infrastructure Library (ITIL)) best practices for information technology policy and procedure to ensure proper execution of this change management issue.

Target Completion Date: 07/31/04

Recommendation B: Modify procedures to include criteria for determining when a change is considered an emergency change and the approval requirements including the timeframe.

Response: Concur—in process. MIHS HIT will leverage the Information Technology Infrastructure Library (ITIL) best practices for information technology policy and procedure to ensure proper execution of this change management issue.

Target Completion Date: 07/31/04

Recommendation C: Retain approvals to provide an audit trail in the event of unforeseen negative impacts on the production environment.

Response: Concur—in process. MIHS HIT will leverage the Information Technology Infrastructure Library (ITIL) best practices for information technology policy and procedure to ensure proper execution of this change management issue.

Target Completion Date: 07/31/04

ISSUE 8 – SYSTEM RECOVERY

Issue #8:

Response: Concur

Recommendation A: Update the DRP to include the payroll and materials management modules of the finance system.

Response: Concur—not started. MIHS HIT will be updating our DRP policy and procedures to include payroll and materials management.

Target Completion Date: 07/31/04

Recommendation B: Establish recovery objectives considering the amount of time that the business can function using manual processes before critical systems are restored.

Response: Concur—not started. MIHS HIT will be updating our DRP policy and procedures to establish recovery objectives for the amount of time that the business can function using manual processes before critical systems are restored.

Target Completion Date: 07/31/04

Recommendation C: Formalize processes to periodically test the ability to recover systems from backup tapes, track the number of uses and age of backup tapes, and replace tapes when necessary.

Response: Concur—not started. MIHS HIT will leverage the Information Technology Infrastructure Library (ITIL) best practices for information technology policy and procedure to back up and recovery processes.

Target Completion Date: 07/31/04

Recommendation D: Retain formal documentation supporting periodic tests to recover systems.

Response: Concur— not started. MIHS HIT will leverage the Information Technology Infrastructure Library (ITIL) practices for the creation of a policy and procedure for storage management/retention and recovery processes.

Target Completion Date: 07/31/04

Recommendation E: Remove the terminated employees from the approved list to obtain tapes from the backup site and establish a process to ensure that individuals are removed promptly upon termination.

Response: Concur—not started. MIHS HIT will leverage the Information Technology Infrastructure Library (ITIL) best practices for the creation of a policy and procedure for storage management/retention and recovery processes.

Target Completion Date: 07/31/04

Recommendation F: Distribute information cards to individuals responsible for obtaining tapes from the off-site vendor and instruct these individuals to carry the cards with them at all times, i. e., in their wallet or purse.

Response: do not concur – currently third party vendor provides this service.

Target Completion Date: n/a

ISSUE 9 – DATA INTEGRITY TESTING

Issue #9:

We identified discrepancies within the Patient Accounting Module's charge description master file, used to calculate a patient's bill. These control weaknesses increase the risk that patient billing may not be accurate. MIHS took action during the audit to correct the discrepancies. MIHS should now develop a process to validate data on an ongoing basis.

Recommendation: MIHS should develop a data integrity quality process to check for data input errors after entry into the system, on an on-going basis.

Response: Concur—not started.

Target Completion Date: 07/31/04

Approved By:

Department Head/Elected Official	**Date** 7/15/03
Chief Officer	**Date** 7/15/03
County Administrative Officer	**Date** 7/21/03